

# Medical Benefits Summary

| Plan Features   | CIGNA Healthcare (POS)   |   | United Healthcare (PPO)   |   |
|---|--|---|---|---|
|   | (In-Network)   | (Out-of-Network)  | (In-Network)  | (Out-of-Network)  |
| <b>Plan Deductible</b><br><i>(per calendar year)</i><br>Individual<br>Family  | \$0<br>\$0   | \$200<br>\$600  | \$300<br>\$900  | \$600<br>\$900  |
| <b>Coinsurance Limit</b><br>Individual<br>Family  | \$500<br>\$1,000   | \$3,000<br>\$6,000  | \$1,800<br>\$3,900  | \$5,600<br>\$10,900   |
| <b>Lifetime Maximum</b><br>(per covered person)   | Unlimited  | \$500,000   | Unlimited   | \$500,000   |
| <b>Physician Services</b><br><i>(except Mental Health/Alc/Drug)</i><br>Office Visits<br><br>Routine Physical<br><br>Well Baby Care<br>(Immunizations)<br><br>Routine Ob/Gyn Exam<br><br>Routine Mammography/Pap Test<br><br>Prostate &<br>Colonrectal Exam<br><br>Specialist <i>(office visits)</i> | 100% after \$20 per visit copay<br><br>100% after \$20 per visit copay<br><br>No Charge<br><br>100% after \$20 per visit copay<br><i>(on a self-referred basis to a network provider)</i><br><br>No Charge<br><br>No Charge<br><br>100% after \$25 per visit copay | 50% after deductible<br><br>Not covered<br><br>Not covered<br><br>Not covered<br><br>50% after deductible<br><br>50% after deductible<br><br>50% after deductible   | 85% after deductible<br><br>Not covered<br><br>85% after deductible<br><br>85% after deductible<br><br>85% after deductible<br><i>(1 per person per calendar year)</i><br><br>85% after deductible<br><i>(Starting at age 40)</i><br><br>85% after deductible | 65% after deductible<br><br>Not covered<br><br>65% after deductible<br><br>65% after deductible<br><br>65% after deductible<br><i>(1 per person per calendar year)</i><br><br>65% after deductible<br><i>(Starting at age 40)</i><br><br>65% after deductible |
| <b>Diagnostic X-ray &amp; Laboratory</b><br><i>(other than physician's office)</i>  | 95%  | 50% after deductible  | 85% after deductible  | 65% after deductible  |
| <b>Ambulance</b>  | 95%  | 95%   | 80% after deductible  | 80% after deductible  |
| <b>Maternity</b>  | \$25 copay first visit, then 95% all other visits  | 50% after deductible  | 85% after deductible  | 65% after deductible  |
| <b>Hospital Services</b><br>Inpatient Coverage<br><br>Outpatient Coverage<br><br>Emergency Room<br><br>Physician In-Hospital Services<br><br>Urgent Care Facility   | \$150 per admission, then 95%<br><br>95%<br><br>100% after \$75 per visit copay<br><i>(waived if confined)</i><br><br>95%<br><br>\$25 per visit copay, then 100%   | \$150 per admission, then 50% after deductible<br><br>50% after deductible<br><br>100% after \$75 per visit copay<br><i>(waived if confined)</i><br><br>50% after deductible<br><br>\$25 per visit copay, then 100% | 85% after deductible plus \$150 copay per confinement<br><br>85% after deductible<br><br>85% after deductible<br>Additional \$75 per visit copay<br><i>(waived if confined)</i><br><br>85% after deductible<br><br>85% after deductible                       | 65% after deductible plus \$150 copay per confinement<br><br>65% after deductible<br><br>65% after deductible<br>Additional \$75 per visit copay<br><i>(waived if confined)</i><br><br>65% after deductible<br><br>65% after deductible                       |
| <b>Skilled Nursing Facility</b>   | 95%<br>(70 days calendar year combined max.)   | 50% after deductible<br>(70 days calendar year combined max.)   | 85% after deductible<br>(70 days calendar year combined max.)   | 65% after deductible<br>(70 days calendar year combined max.)   |
| <b>Home Health Care</b>   | No Charge<br>(100 days calendar year max.)   | 50% after deductible<br>(40 days max-reduced by in-network visits)  | 85% after deductible<br>(precertification required)   | 65% after deductible<br>(precertification required)   |
| <b>Rehabilitation Services</b><br>(Physical, Speech, Occupational Therapies, etc.)  | 100% after \$25 per visit copay<br><i>(60 days calendar year combined max.)</i>  | 50% max after deductible<br><i>(60 days calendar year combined max.)</i>  | 85% after deductible  | 65% after deductible  |
| <b>Durable Medical Equipment</b>  | No Charge<br>(per calendar year)   | \$200 additional deductible<br>(precertification required) then 50%; max \$700  | 85% after deductible<br>(precertification required)   | 65% after deductible<br>(precertification required)   |
| <b>External Prosthetic Appliances</b>   | \$200 deductible per calendar year then 100% (max \$1,000)   | No charge after deductible (max \$1,000)  | 85% after deductible  | 65% after deductible  |
| <b>Precertification</b><br>Penalty to Employee for Failure to Precertify  | Provider initiated<br><br>None   | Member initiated<br>\$500 penalty<br><i>(per admission)</i>   | Member initiated<br>\$500 penalty<br><i>(per admission)</i>   | Member initiated<br>\$500 penalty<br><i>(per admission)</i>   |
| <b>Medical Claim Submission</b>   | Provider initiated   | Member initiated  | Provider initiated  | Member initiated  |
| <b>Prescription Drugs</b>   | <b>CIGNA POS</b>   |   | <b>UNITED HEALTHCARE PPO</b>  |   |
| <b>Express Scripts</b>  | <b>Deductible</b>  | None  | <b>Deductible</b>   | \$150 (RX Only)   |
|   | <b>Retail Benefit</b><br><i>(Walk-In)</i>  | \$10 Generic<br>\$25 Formulary Brand<br>\$55 Non-Formulary Brand  | <b>Retail Benefit</b><br><i>(Walk-In)</i>   | 20% Generic<br>20% Formulary Brand w/ Generic Buy-up<br>40% Non-Formulary Brand   |
|   | <b>Home Delivery Benefit</b><br><b>(90 days supply)</b>  | \$20 Generic<br>\$50 Formulary Brand<br>\$110 Non-Formulary Brand   | <b>Home Delivery Benefit</b><br><b>(90 days supply)</b>   | \$10 Generic<br>\$50 Formulary Brand<br>\$110 Non-Formulary Brand   |
| <b>MONTHLY PREMIUMS</b>   | <b>CIGNA HEALTHCARE (POS PLAN)</b>   |   | <b>UNITED HEALTHCARE (PPO PLAN)</b>   |   |
|   | <b>Single</b>  | <b>Family</b>   | <b>Single</b>   | <b>Family</b>   |
|   | <b>\$152.60</b>  | <b>\$313.06</b>   | <b>\$173.16</b>   | <b>\$355.56</b>   |

**MONTHLY RATES AND COVERAGE - EFFECTIVE OCTOBER 1, 2006**

The benefits of these plans are described in the plan documents with Shelby County Government. The terms and provisions of the plan documents are controlling and none of the conditions or limitations are waived or modified by reason of any omission from this comparison. Revised January 1, 2006

**Pre-existing Condition Clause** - Once an enrolled person has been in a health plan through Shelby County Government for a continuous 12 month period (contributions must have been paid for each of the twelve months), the pre-existing condition stipulation in the United Healthcare PPO and CIGNA Health Care Plan (when not coordinating care with your primary care physician) is no longer applicable.

**Shelby County Government Employee Benefits of ineligible dependents.**

**Must provide proof of enrollment for dependents age 19 to 25. It is the employee's responsibility to notify**

# MEDICAL BENEFITS SUMMARY

## SHELBY COUNTY HEADSTART



### MENTAL HEALTH AND SUBSTANCE ABUSE COVERAGE EMPLOYEE ASSISTANCE PROGRAM (EAP)

**This is a separate Plan for all participants in any Shelby County Medical Coverage Plan - no mental health or substance abuse coverage will be provided through the United Healthcare PPO or CIGNA POS plans.**

If you have been employed by Shelby County for at least six months and you are enrolled in a Shelby County Medical Plan, you are eligible for the Mental Health and Substance Abuse Plan. If you have family coverage and your enrolled dependent has been covered for six months in a row, that dependent is also covered.

**For any benefits to be paid, treatment must be coordinated in advance through the County's Employee Assistance Program (EAP).**

**EAP phone (901) 458-0966 (after-hours pager (901) 728-9810).**

There is no charge and no limit for outpatient treatment provided by the Shelby County EAP Mental Health Specialists. If more care is approved by the EAP, benefits are paid as shown under "Additional Outpatient Care."

| Your choice of providers          | When you use an EAP Preferred Provider  | When you use any other qualified provider and have EAP signed approval |
|-----------------------------------|---|--|
| <b>Plan Pays</b>                  | Plan pays <b>100%</b>   | Plan pays <b>50%</b> of eligible expenses within U&C cost limits.      |
| <b>Inpatient Care</b>             | <p><b>Mental Illness treatment</b> is limited to 30 days of care in a calendar year.</p> <p><b>Substance abuse treatment</b> is limited to 30 days of care in a calendar year - and is limited to one treatment series per year and two treatment series within any five-year period.</p> <p>Adolescents and children may, in special circumstances, receive an additional 30 days of residential care.</p> <p>There is a \$150 per admission charge for each diagnosis if not through EAP Preferred Provider.</p>                              |  |
| <b>Additional Outpatient Care</b> | <ul style="list-style-type: none"> <li>● You pay \$10 per visit when using an EAP Preferred Provider (does not apply to Retirees with Part B Medicare).</li> <li>● Mental illness treatment is limited to 26 visits each calendar year.</li> <li>● Substance abuse treatment is limited to a calendar year benefit of \$1,500 - with additional \$1,500 calendar year benefit if you use an EAP Preferred Provider (a \$3,000 benefit if you use only an EAP Preferred Provider). No benefit paid if treatment series not completed.</li> </ul> |  |

**Per-visit charges and hospitalization admission charges under the Mental Health and Substance Abuse Coverage Plan do not apply toward any medical plan deductibles or out-of-pocket limits.**